Request - Family Medical Leave of Absence
(Please Print)

Request for Family or Medical Leave (FMLA leave) must be made, if practical, at least 30 days prior to the date requested leave is to begin.

Name Patrick Landis Date: 9/8/17

Address 3755 Cornwallis RD SS# 242-49-3174

Garner NC 27529 Home Phone # 919-625-8727

Employment Status
(Check one) ✓Full Time ___Part Time ___Temporary

Hire Date 12/8/08 **Length of Service** 8 years 10 months

Request for Leave

I request family or medical leave for one or more of the following reasons:

___ Birth or placement for adoption of a child and in order to care for this child.

Expected Date of Birth or Adoption _____

Leave to Start ___/___/___ Expected Date of Return ___/___/___

X In order to care for my spouse, child, or parent who needs my care due to a serious health condition.

Leave to Start 9/8/17 Expected Date of Return 12/8/17

___ For serious health condition that makes me unable to perform my job.

Provide Physician's Certification form.

Leave to Start ___/___/___ Expected Date of Return ___/___/___

___ Intermittent or reduced hours leave schedule (if applicable; subject to company approval).

Describe: _____

_____

Department Head Signature: _____ Date: ___/___/___

EMPLOYEE BENEFITS SECTION

Please complete the following section

- Have you taken family or medical leave in the past 12 months?

☐ Yes ____ ☒ No ____ If yes, how many work days? _____

The following terms and conditions are applicable to your requested FMLA leave of absence, if granted.

- You must have been employed at least 12 months and worked 1,250 hours in the past 12 months.
- Failure to provide a medical certification, if requested, will result in a denial of FMLA leave.
- You may use any paid leave to which you are entitled, or the company may require you to exhaust your sick leave, personal, or vacation as part of your FMLA leave. You must notify us if you want to use paid leave, and the company will notify you if you must exhaust your accrued paid leave.
- A fitness for duty certificate is required of all employees returning from leave after a serious health condition.
- You will be reinstated upon return from a FMLA leave to an equivalent position.
- If you fail to return to work after the leave, you will be financially responsible for the total cost (employer and employee portions) of any and all benefits maintained during FMLA leave.
- When you return to work you must repay any amount due for the continuance of employee benefits during FMLA leave and the appropriate amount will be withheld from your paychecks.
- After the leave period specified above, if you do not return to work or contact your supervisor or manager on the date of scheduled return, you will be considered to have resigned your position with the City of Raleigh.

_____ 9/8/17

Employee Signature DATE

Attachment A-2

Employees on Leave of Absence

Election to Continue or Cancel
Optional Benefit Coverage

Employee Name: Lands (Last) Patrick (First) D (MI)

SSN: 242 - 49 - 3174

Leave Dates: From: 9/8/17, 2017 to 12/8, 2017

Type of Leave: ✓ FMLA _____ SPECIAL LEAVE (unpaid only)

Specify if regular sick, extended sick or vacation pay leave is to be used below:

Paid: YES ✓ NO ____ From: 9/8/17 To: 12/8/17 Sick/comp

Unpaid: YES ____ NO ____ From: _____ To: _____

Based on the type of Leave of Absence that you are requesting, you may choose one of the following options with regard to the continuation or cancellation of your optional coverage benefits.

[___] I elect not to continue any benefit coverage during my leave of absence, and I understand that the City of Raleigh will cancel these coverages.

[___] I elect to continue those benefit coverages that I have indicated from the attached sheet. I understand that the premiums for these benefits are due in advance and must be received by the 25th of each month to continue coverage for the following month. Arrangements will be made with the City of Raleigh Payroll Office to prepay this amount in advance at the beginning of the leave period or to make payment monthly. Failure to pay timely will result in the cancellation of these coverages.

[___] If qualified for Family Medical Leave (FMLA), I understand that medical, dental and basic life coverage for me will continue to be provided by the city at no cost. Premiums for dependent medical, dental and basic life coverage can be deferred until I return to work from FMLA at which time the Payroll Office will work out a payment schedule to repay these amounts via payroll deduction. I further understand that if I do not return to work or if my FMLA ends and I am approved for additional Leave Without Pay, that all missed benefit premium coverages are due to the City of Raleigh at that time, and that I am required to pay the premiums for medical, dental & life coverage on myself at this point until I return to active work with the City of Raleigh.

[✓] I have sufficient accruals of Sick, Extended Sick, and/or Vacation Leave to cover my time away from work. All of my current deductions may continue normally.

Attachment A-2

Please fill in all payroll deductions that you wish to continue:

Benefit Coverage	Amount
Health Insurance – Employee – Paid by city while actively working	
Spouse/Dependent	
Dental Insurance – Employee – Paid by city while actively working	
Spouse/Dependent	
Basic Life Insurance – Employee – Paid by city while actively working	
Spouse/Dependent	
Voluntary Life Insurance – Employee	
Spouse	
Dependent	
NC Mutual Life Insurance	
Disability Income Plan	
Critical Illness	
Credit Union – Shares	
Loan	
Fire Pension	
Supplemental Retirement Loan	
401k Loan	
Child Support Garnishment (County_____)	
Tax Garnishments (Federal, State, & County)	
Bankruptcy Payments	
United Way	
Professional Dues: RPFA	
RPPA	
Total Deductions Continue as normal	$_____

I understand that if my benefit coverage/deductions are not paid according to the payment election indicated above that my benefits coverage will be cancelled by the City of Raleigh.

_____ _____
Employee Signature Witness

9/8/17 _____
Date Date

Certification of Health Care Provider for Family Member's Serious Health Condition (Family and Medical Leave Act)

U.S. Department of Labor
Wage and Hour Division

DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR. RETURN TO THE PATIENT.

OMB Control Number 1235-0003
Expires: 5/31/2018

SECTION I: For Completion by the EMPLOYER

INSTRUCTIONS to the EMPLOYER: The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA protections because of a need for leave to care for a covered family member with a serious health condition to submit a medical certification issued by the health care provider of the covered family member. Please complete Section I before giving this form to your employee. Your response is voluntary. While you are not required to use this form, you may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. §§ 825.306-825.308. Employers must generally maintain records and documents relating to medical certifications, recertifications, or medical histories of employees' family members, created for FMLA purposes as confidential medical records in separate files/records from the usual personnel files and in accordance with 29 C.F.R. § 1630.14(c)(1), if the Americans with Disabilities Act applies, and in accordance with 29 C.F.R. § 1635.9, if the Genetic Information Nondiscrimination Act applies.

Employer name and contact: _____

SECTION II: For Completion by the EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: Please complete Section II before giving this form to your family member or his/her medical provider. The FMLA permits an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave to care for a covered family member with a serious health condition. If requested by your employer, your response is required to obtain or retain the benefit of FMLA protections. 29 U.S.C. §§ 2613, 2614(c)(3). Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request. 29 C.F.R. § 825.313. Your employer must give you at least 15 calendar days to return this form to your employer. 29 C.F.R. § 825.305.

Your name: Patrick (First) Dale (Middle) Landis (Last)

Name of family member for whom you will provide care: [redacted] (First Middle Last)

Relationship of family member to you: Father

If family member is your son or daughter, date of birth: _____

Describe care you will provide to your family member and estimate leave needed to provide care:

Father was involved in car crash causing [redacted]

[redacted]

Employee Signature _____ Date 9/8/17

SECTION III: For Completion by the HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER: The employee listed above has requested leave under the FMLA to care for your patient. Answer, fully and completely, all applicable parts below. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage. Limit your responses to the condition for which the patient needs leave. Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), or genetic services, as defined in 29 C.F.R. § 1635.3(e). Page 3 provides space for additional information, should you need it. Please be sure to sign the form on the last page.

Provider's name and business address: Lars Gardner DO 5838 Six Forks Road Raleigh, NC 27609

Type of practice / Medical specialty: Neurosurgery

Telephone: (919) 785-3400 Fax: (919) 783-7810

PART A: MEDICAL FACTS

1. Approximate date condition commenced: 8/25/17

Probable duration of condition: 8/25/17 - 11/25/17 approx, 1 month intermittent leave

Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?
___No X Yes. If so, dates of admission: 8/23/17 - 8/28/17

Date(s) you treated the patient for condition: 8/25/17, 9/8/17

Was medication, other than over-the-counter medication, prescribed? ___No X Yes.

Will the patient need to have treatment visits at least twice per year due to the condition? ___No ___ Yes possibly

Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)?
X No ____Yes. If so, state the nature of such treatments and expected duration of treatment:

N/A

2. Is the medical condition pregnancy? X No ___Yes. If so, expected delivery date: X

3. Describe other relevant medical facts, if any, related to the condition for which the patient needs care (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):

M48.02, S129XXA

[redacted]

Employee requires 1 month intermittent leave during the period of 8/25/17 to 11/25/17 to help patient recover from surgery.

 CONTINUED ON NEXT PAGE

PART B: AMOUNT OF CARE NEEDED: When answering these questions, keep in mind that your patient's need for care by the employee seeking leave may include assistance with basic medical, hygienic, nutritional, safety or transportation needs, or the provision of physical or psychological care:

4. Will the patient be incapacitated for a single continuous period of time, including any time for treatment and recovery? ___No X Yes.

   Estimate the beginning and ending dates for the period of incapacity: 8/25/17 - 11/25/17 Approx

   During this time, will the patient need care? ___No X Yes.

   Explain the care needed by the patient and why such care is medically necessary:

   Patient will require help w/ ADLs, transportation to and from appointments, etc.

5. Will the patient require follow-up treatments, including any time for recovery? ~~No~~ ~~Yes~~. possibly

   Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period:

   Cannot estimate @ this time

   Explain the care needed by the patient, and why such care is medically necessary: Patient is recovering from [redacted] and requires help w/ ADLs, transportation, etc.

6. Will the patient require care on an intermittent or reduced schedule basis, including any time for recovery? ___ No X Yes.

   Estimate the hours the patient needs care on an intermittent basis, if any:

   ~~____ hour(s) per day; ____ days per week from ____ through ____~~

   Explain the care needed by the patient, and why such care is medically necessary:

   Employee, Patrick Lands, requires one month intermittent leave from 8/25/17 to 11/25/17 to help patient recover from [redacted].

7. Will the condition cause episodic flare-ups periodically preventing the patient from participating in normal daily activities? ___ ~~No~~ ___ ~~Yes~~. possibly

Based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the patient may have over the next 6 months (e.g., 1 episode every 3 months lasting 1-2 days):

Frequency: ____ times per ____ week(s) ____ month(s)

Duration: ____ hours ~~or~~ ____ day(s) per episode

Does the patient need care during these flare-ups? ____ No X Yes.

Explain the care needed by the patient, and why such care is medically necessary: _____

Cannot medically estimate flare-ups

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

Employee will require one month of intermittent leave during the period of 8/25/17 to 11/25/17 approx. to help patient recover from surgery

Signature of Health Care Provider

9/11/17
Date

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

If submitted, it is mandatory for employers to retain a copy of this disclosure in their records for three years. 29 U.S.C. § 2616; 29 C.F.R. § 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 20 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Ave., NW, Washington, DC 20210.
DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR; RETURN TO THE PATIENT.

Certification of Health Care Provider for Family Member's Serious Health Condition (Family and Medical Leave Act)

U.S. Department of Labor
Wage and Hour Division

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OMB Control Number 1235-0003
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SECTION I: For Completion by the EMPLOYER

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Employer name and contact: City of Raleigh/Human Resources/Benefits Division

phone: 919-996-3315 fax: 919-996-7611

SECTION II: For Completion by the EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: Please complete Section II before giving this form to your family member or his/her medical provider. The FMLA permits an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave to care for a covered family member with a serious health condition. If requested by your employer, your response is required to obtain or retain the benefit of FMLA protections. 29 U.S.C. §§ 2613, 2614(c)(3). Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request. 29 C.F.R. § 825.313. Your employer must give you at least 15 calendar days to return this form to your employer. 29 C.F.R. § 825.305.

Your name: Patrick (First) _____ (Middle) Lands (Last)

Name of family member for whom you will provide care: [redacted]

Relationship of family member to you: Father

If family member is your son or daughter, date of birth: _____

Describe care you will provide to your family member and estimate leave needed to provide care:

_____

_____

_____

Employee Signature _____ Date _____

SECTION III: For Completion by the HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER: The employee listed above has requested leave under the FMLA to care for your patient. Answer, fully and completely, all applicable parts below. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage. Limit your responses to the condition for which the patient needs leave. Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), or genetic services, as defined in 29 C.F.R. § 1635.3(e). Page 3 provides space for additional information, should you need it. Please be sure to sign the form on the last page.

Provider's name and business address: Lars Gardner | 5838 Six Forks Rd. Suite 100 Raleigh, NC 27609

Type of practice / Medical specialty: Neurosurgery

Telephone: (919) 785 - 3400 Fax: (919) 783 - 7810

PART A: MEDICAL FACTS

1. Approximate date condition commenced: August 25, 2017

Probable duration of condition: Aug. 25, 2017 until deemed no longer a medical necessity

Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?
___No X Yes. If so, dates of admission: Aug. 23 to Aug. 28, 2017

Date(s) you treated the patient for condition: 8.25.17, 9.8.17, 9.22.17, 11.20.17, 12.18.17

Was medication, other than over-the-counter medication, prescribed? ___No X Yes.

Will the patient need to have treatment visits at least twice per year due to the condition? ~~No~~ ~~Yes~~ possibly

Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)?
X No ___Yes. If so, state the nature of such treatments and expected duration of treatment:

N/A

2. Is the medical condition pregnancy? X No ___Yes. If so, expected delivery date: ~~—~~

3. Describe other relevant medical facts, if any, related to the condition for which the patient needs care (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):

[redacted]

Employee requires intermittent leave during this time from 8.25.17 until deemed no longer a medical necessity.

PART B: AMOUNT OF CARE NEEDED: When answering these questions, keep in mind that your patient's need for care by the employee seeking leave may include assistance with basic medical, hygienic, nutritional, safety or transportation needs, or the provision of physical or psychological care:

4. Will the patient be incapacitated for a single continuous period of time, including any time for treatment and recovery? ___No X Yes.

Estimate the beginning and ending dates for the period of incapacity: 8-25-17 until deemed no longer a medical necessity

During this time, will the patient need care? __ No X Yes.

Explain the care needed by the patient and why such care is medically necessary:

Patient will require help with ADLS, transportation to and from appointments, etc.

5. Will the patient require follow-up treatments, including any time for recovery? ~~No~~ ~~Yes.~~ possibly

Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period:

most recent appointment 12-18-17

Explain the care needed by the patient, and why such care is medically necessary: Patient is recovering [redacted] and will require help with ADLS, transportation, etc.

6. Will the patient require care on an intermittent or reduced schedule basis, including any time for recovery? __ No X Yes.

Estimate the hours the patient needs care on an intermittent basis, if any:

____ hour(s) per day; ____ days per week from ____ through ____

Explain the care needed by the patient, and why such care is medically necessary:

Employee requires leave from 8-25-17 until deemed no longer a medical necessity to help patient recover from [redacted]

7. Will the condition cause episodic flare-ups periodically preventing the patient from participating in normal daily activities? ____No ____Yes.

Based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the patient may have over the next 6 months (e.g., 1 episode every 3 months lasting 1-2 days):

Frequency: _____ times per _____ week(s) _____ month(s)

Duration: _____ hours or ____ day(s) per episode

Does the patient need care during these flare-ups? ____ No ____ Yes.

Explain the care needed by the patient, and why such care is medically necessary: _____

unable to medically predict

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

Employee will require leave from 8.25.17 until deemed no longer medically necessary to help patient recover [redacted]

Signature of Health Care Provider

Dec. 20, 2017
Date

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

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